LEGISLATURE OF THE STATE OF IDAHO

Sixty-second Legislature First Regular Session - 2013

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 98, As Amended, As Amended in the Senate

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO MEDICAL INDIGENCY; AMENDING SECTION 31-3501, IDAHO CODE, TO REVISE THE DECLARATION OF POLICY TO INCLUDE DEPENDENTS; AMENDING SECTION 31-3502, IDAHO CODE, TO REVISE DEFINITIONS; AMENDING SECTION 31-3504, IDAHO CODE, TO REVISE PROVISIONS RELATING TO SUBMISSION OF MEDICAL RECORDS AND MEDICAL CLAIMS AS PART OF AN APPLICATION FOR FINANCIAL ASSISTANCE; AMENDING SECTION 31-3505, IDAHO CODE, TO REVISE TERMINOLOGY; AMENDING SECTION 31-3505A, IDAHO CODE, TO PROVIDE THAT FINDINGS OF INDIGENCY SHALL START ON THE DATE NECESSARY MEDICAL SERVICES ARE FIRST PROVIDED; AND AMENDING SECTION 31-3508A, IDAHO CODE, TO REVISE TERMINOLOGY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 31-3501, Idaho Code, be, and the same is hereby amended to read as follows:

31-3501. DECLARATION OF POLICY. (1) It is the policy of this state that each person, to the maximum extent possible, is responsible for his or her own medical care and that of his or her dependents and to that end, shall be encouraged to purchase his or her own medical insurance with coverage sufficient to prevent them from needing to request assistance pursuant to this chapter. However, in order to safeguard the public health, safety and welfare, and to provide suitable facilities and provisions for the care and hospitalization of persons in this state, and, in the case of medically indigent residents, to provide for the payment thereof, the respective counties of this state, and the board and the department shall have the duties and powers as hereinafter provided.

(2) The county medically indigent program and the catastrophic health care cost program are payers of last resort. Therefore, applicants or third party applicants seeking financial assistance under the county medically indigent program and the catastrophic health care cost program shall be subject to the limitations and requirements as set forth herein.

SECTION 2. That Section 31-3502, Idaho Code, be, and the same is hereby amended to read as follows:

31-3502. DEFINITIONS. As used in this chapter, the terms defined in this section shall have the following meaning, unless the context clearly indicates another meaning:

(1) "Applicant" means any person who is requesting financial assistance under this chapter.

(2) "Application" means the combined application for state and county medical assistance pursuant to sections 31-3504 and 31-3503E, Idaho Code.

In this chapter an application for state and county medical assistance shall also mean an application for financial assistance.

(3) "Board" means the board of the catastrophic health care cost program, as established in section 31-3517, Idaho Code.

(4) "Case management" means coordination of services to help meet a patient's health care needs, usually when the patient has a condition that requires multiple services.

(5) "Catastrophic health care costs" means the cost of necessary medical services received by a recipient that, when paid at the then existing reimbursement rate, exceeds the total sum of eleven thousand dollars ($11,000) in the aggregate in any consecutive twelve (12) month period.

(6) "Clerk" means the clerk of the respective counties or his or her designee.

(7) "Completed application" shall include at a minimum the cover sheet requesting services, applicant information including diagnosis and requests for services and signatures, personal and financial information of the applicant and obligated person or persons, patient rights and responsibilities, releases and all other signatures required in the application.

(8) "County commissioners" means the board of county commissioners in their respective counties.

(9) "County hospital" means any county approved institution or facility for the care of sick persons.

(10) "Department" means the department of health and welfare.

(11) "Dependent" means any person whom a taxpayer ~~could~~ claims as a dependent under the income tax laws of the state of Idaho.

(12) "Emergency service" means a service provided for a medical condition in which sudden, serious and unexpected symptoms of illness or injury are sufficiently severe to necessitate or call for immediate medical care, including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(13) "Hospital" means a facility licensed and regulated pursuant to sections 39-1301 through 39-1314, Idaho Code, or an out-of-state hospital providing necessary medical services for residents of Idaho, wherein a reciprocal agreement exists, in accordance with section 31-3503B, Idaho Code, excluding state institutions.

(14) "Medicaid eligibility review" means the process used by the department to determine whether a person meets the criteria for medicaid coverage.

(15) "Medical claim" means the itemized statements and standard forms used by hospitals and providers to satisfy centers for medicare and medicaid services (CMS) claims submission requirements.

(16) "Medical home" means a model of primary and preventive care delivery in which the patient has a continuous relationship with a personal physician in a physician directed medical practice that is whole person oriented and where care is integrated and coordinated.

(17) "Medically indigent" means any person who is in need of necessary medical services and who, if an adult, together with his or her spouse, or whose parents or guardian if a minor or dependent, does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services. Nothing in this definition shall prevent the board and the county commissioners from requiring the applicant and obligated persons to reimburse the county and the catastrophic health care cost program, where appropriate, for all or a portion of their medical expenses, when investigation of their application pursuant to this chapter, determines their ability to do so.

(18) A. "Necessary medical services" means health care services and supplies that:

(a) Health care providers, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms;

(b) Are in accordance with generally accepted standards of medical practice;

(c) Are clinically appropriate, in terms of type, frequency, extent, site and duration and are considered effective for the covered person's illness, injury or disease;

(d) Are not provided primarily for the convenience of the person, physician or other health care provider; and

(e) Are the most cost-effective service or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury or disease.

B. Necessary medical services shall not include the following:

(a) Bone marrow transplants;

(b) Organ transplants;

(c) Elective, cosmetic and/or experimental procedures;

(d) Services related to, or provided by, residential, skilled nursing, assisted living and/or shelter care facilities;

(e) Normal, uncomplicated pregnancies, excluding caesarean section, and childbirth well-baby care;

(f) Medicare copayments and deductibles;

(g) Services provided by, or available to, an applicant from state, federal and local health programs;

(h) Medicaid copayments and deductibles; and

(i) Drugs, devices or procedures primarily utilized for weight reduction and complications directly related to such drugs, devices or procedures.

(19) "Obligated person" means the person or persons who are legally responsible for an applicant including, but not limited to, parents of minors or dependents.

(20) "Primary and preventive health care" means the provision of professional health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems and the overall management of an individual's health care services.

(21) "Provider" means any person, firm or corporation certified or licensed by the state of Idaho or holding an equivalent license or certification in another state, that provides necessary medical services to a patient requesting a medically indigent status determination or filing an application for financial assistance.

(22) "Recipient" means an individual determined eligible for financial assistance under this chapter.

(23) "Reimbursement rate" means the unadjusted medicaid rate of reimbursement for medical charges allowed pursuant to title XIX of the social security act, as amended, that is in effect at the time service is rendered. Beginning July 1, 2011, and sunsetting July 1, 201~~3~~4, "reimbursement rate" shall mean ninety-five percent (95%) of the unadjusted medicaid rate.

(24) "Resident" means a person with a home, house, place of abode, place of habitation, dwelling or place where he or she actually lived for a consecutive period of thirty (30) days or more within the state of Idaho. A resident does not include a person who comes into this state for temporary purposes, including, but not limited to, education, vacation, or seasonal labor. Entry into active military duty shall not change a person's residence for the purposes of this chapter. Those physically present within the following facilities and institutions shall be residents of the county where they were residents prior to entering the facility or institution:

(a) Correctional facilities;

(b) Nursing homes or residential or assisted living facilities;

(c) Other medical facility or institution.

(25) "Resources" means all property, for which an applicant and/or an obligated person may be eligible or in which he or she may have an interest, whether tangible or intangible, real or personal, liquid or nonliquid, or pending, including, but not limited to, all forms of public assistance, crime victims compensation, worker's compensation, veterans benefits, medicaid, medicare, supplemental security income (SSI), third party insurance, other insurance or apply for section 1011 of the medicare modernization act of 2003, if applicable, and any other property from any source. Resources shall include the ability of an applicant and obligated persons to pay for necessary medical services, excluding any interest charges, over a period of up to five (5) years <u>starting on the date necessary medical services are first provided</u>. For purposes of determining approval for medical indigency only, resources shall not include the value of the homestead on the applicant or obligated person's residence, a burial plot, exemptions for personal property allowed in section 11-605(1) through (3), Idaho Code, and additional exemptions allowed by county resolution.

(26) "Third party applicant" means a person other than an obligated person who completes, signs and files an application on behalf of a patient. A third party applicant who files an application on behalf of a patient pursuant to section 31-3504, Idaho Code, shall, if possible, deliver a copy of the application to the patient within three (3) business days after filing the application.

(27) "Third party insurance" means casualty insurance, disability insurance, health insurance, life insurance, marine and transportation insurance, motor vehicle insurance, property insurance or any other insurance coverage that may pay for a resident's medical bills.

(28) "Utilization management" means the evaluation of medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities. "Utilization management" may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, case management, preauthorization of ambulatory procedures, retrospective review and claims review. "Utilization management" may also include the amount to be paid based on the application of the reimbursement rate to those medical services determined to be necessary medical services.

SECTION 3. That Section 31-3504, Idaho Code, be, and the same is hereby amended to read as follows:

31-3504. APPLICATION FOR FINANCIAL ASSISTANCE. (1) Except as provided for in section 31-3503E, Idaho Code, an applicant or third party applicant requesting assistance under this chapter shall complete a written application. The truth of the matters contained in the completed application shall be sworn to by the applicant or third party applicant. The completed application shall be deemed consent for the providers, the hospital, the department, respective counties and board to exchange information pertaining to the applicant's health and finances for the purposes of determining medicaid eligibility or medical indigency. The completed application shall be signed by the applicant or third party applicant, an authorized representative of the applicant, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant and filed in the clerk's office. If the clerk determines that the patient may be eligible for medicaid, within one (1) business day of the filing of the completed application in the clerk's office, the clerk shall transmit a copy of the application and a written request for medicaid eligibility determination to the department.

(a) If, based on its medicaid eligibility review, the department determines that the patient is eligible for medicaid, the department shall act on the application as an application for medicaid.

(b) If, based on its medicaid eligibility review, the department determines that the patient is not eligible for medicaid, the department shall notify the clerk of the denial and the reason therefor, in accordance with section 31-3503E, Idaho Code. Denial of medicaid eligibility is not a determination of medical indigence.

(2) If a third party completed application is filed, the application shall be presented in the same form and manner as set forth in subsection (1) of this section.

(3) Follow-up necessary medical services based on a treatment plan, for the same condition, preapproved by the county commissioners, may be provided for a maximum of six (6) months from the date of the original application without requiring an additional application; however, a request for additional treatment not specified in the approved treatment plan shall be filed with the clerk ten (10) days prior to receiving services. Beyond the six (6) months, requests for additional treatment related to an original diagnosis in accordance with a preapproved treatment plan shall be filed ten (10) days prior to receiving services and an updated application may be requested by the county commissioners.

(4) Upon application for financial assistance pursuant to this chapter an automatic lien shall attach to all real and personal property of the applicant and on insurance benefits to which the applicant may become entitled. The lien shall also attach to any additional resources to which it may legally attach not covered in this section. The lien created by this section may be, in the discretion of the county commissioners and the board, perfected as to real property and fixtures by recording a document entitled: notice of lien and application for financial assistance, in any county recorder's office in this state in which the applicant and obligated person own property. The notice of lien and application for financial assistance shall be recorded as provided herein within thirty (30) days from receipt of an application, and such lien, if so recorded, shall have a priority date as of the date the necessary medical services were provided. The lien created by this section may also be, in the discretion of the county commissioners and the board, perfected as to personal property by filing with the secretary of state within thirty (30) days of receipt of an application, a notice of application in substantially the same manner as a filing under chapter 9, title 28, Idaho Code, except that such notice need not be signed and no fee shall be required, and, if so filed, such lien shall have the priority date as of the date the necessary medical services were provided. An application for assistance pursuant to this chapter shall waive any confidentiality granted by state law to the extent necessary to carry out the intent of this section.

(5) In accordance with rules and procedures promulgated by the department or the board, each hospital and provider seeking reimbursement under this chapter shall submit all ~~known billings for~~ medical records and medical claims relevant to necessary medical services provided for ~~each~~ an applicant in a standard or uniform format to the ~~department's or the board's contractor for its utilization management review within ten (10) business days of receiving notification that the patient is not eligible for medicaid~~ county clerk of the obligated county within ten (10) days after receiving a request from the county clerk; provided that, within the ten (10) day period ~~upon a showing of good cause~~ if a provider presents a written request for suspension of the investigation, the ~~time period~~ investigation of the application ~~may~~ shall be ~~extended~~ suspended for up to thirty (30) days. Upon receipt of the requested documentation, the investigation shall resume. A copy of the results of the reviewed ~~billings~~ medical records and medical claims shall be transmitted by the department's or the board's contractor to the clerk of the obligated county. Failure to provide the medical records and medical claims within the initial ten (10) day period and the suspension period, if any, shall result in denial of the application.

SECTION 4. That Section 31-3505, Idaho Code, be, and the same is hereby amended to read as follows:

31-3505. TIME AND MANNER OF FILING APPLICATIONS FOR FINANCIAL ASSISTANCE. Applications for financial assistance shall be filed according to the following time limits. Filing is complete upon receipt by the clerk or the department.

(1) A completed application for nonemergency necessary medical services shall be filed with the clerk ten (10) days prior to receiving services from the provider or the hospital.

(2) A completed application for emergency necessary medical services shall be filed with the clerk any time within thirty-one (31) days beginning with the first day of the provision of necessary medical services from the provider, except as provided in subsection (3) of this section.

(3) In the case of hospitalization, a completed application for emergency necessary medical services shall be filed with the department any time within thirty-one (31) days of the date of admission.

(4) Requests for additional treatment related to an original diagnosis in accordance with a preapproved treatment plan shall be filed ten (10) days prior to receiving services.

(5) A delayed application for necessary medical services may be filed up to one hundred eighty (180) days beginning with the first day of the provision of necessary medical services provided that:

(a) Written documentation is included with the application or no later than forty-five (45) days after an application has been filed showing that a bona fide application or claim has been filed for social security disability insurance, supplemental security income, third party insurance, medicaid, medicare, crime victim's compensation, and/or worker's compensation. A bona fide application means that:

(i) The application was timely filed within the appropriate agency's application or claim time period; and

(ii) Given the circumstances of the patient and/or obligated persons, the patient and/or obligated persons, and given the information available at the time the application or claim for other resources is filed, would reasonably be expected to meet the eligibility criteria for such resources; and

(iii) The application was filed with the appropriate agency in such a time and manner that, if approved, it would provide for payment coverage of the bills included in the county application; and

(iv) In the discretion of the county commissioners, bills on a delayed application which would not have been covered by a successful application or timely claim to the other resource(s) may be denied by the county commissioners as untimely; and

(v) In the event an application is filed for supplemental security income, an Idaho medicaid application must also have been filed within the department of health and welfare's application or claim time period to provide payment coverage of eligible bills included in the county application.

(b) Failure by the patient and/or obligated persons to complete the application process described in this section, up to and including any reasonable appeal of any denial of benefits, with the applicable program noted in paragraph (a) of this subsection, shall result in denial of the ~~county assistance~~ application.

(6) No application for financial assistance under the county medically indigent program or the catastrophic health care cost program shall be approved by the county commissioners or the board unless the provider or the hospital completes the application process and complies with the time limits prescribed by this ~~section~~ chapter.

(7) Any application or request which fails to meet the provisions of this section, and/or other provisions of this chapter, shall be denied.

(8) In the event that a county determines that a different county is obligated, such county shall notify the applicant or third party applicant of the denial and shall also notify the county it believes to be the obligated county and provide the basis for the determination. An application may be filed by the applicant or third party applicant in the indicated county within thirty (30) days of the date of the initial county denial.

SECTION 5. That Section 31-3505A, Idaho Code, be, and the same is hereby amended to read as follows:

31-3505A. INVESTIGATION OF APPLICATION BY THE CLERK. (1) The clerk shall interview the applicant and investigate the information provided on the application, along with all other required information, in accordance with the procedures established by the county commissioners, the board and this chapter. The clerk shall promptly notify the applicant, or third party filing an application on behalf of an applicant, of any material information missing from the application which, if omitted, may cause the application to be denied for incompleteness. In addition, any provider requesting notification shall be notified at the same time. When necessary, such persons as may be deemed essential, may be compelled by the clerk to give testimony and produce documents and other evidence under oath in order to complete the investigation. The clerk is hereby authorized to issue subpoenas to carry out the intent of this provision and to otherwise compel compliance in accordance with provisions of Idaho law.

(2) The applicant and third party filing an application on behalf of an applicant to the extent they have knowledge, shall have a duty to cooperate with the clerk in investigating, providing documentation, submitting to an interview and ascertaining eligibility and shall have a continuing duty to notify the obligated county of the receipt of resources after an application has been filed.

(3) The clerk shall have twenty (20) days to complete the investigation of an application for nonemergency necessary medical services.

(4) The clerk shall have forty-five (45) days to complete the investigation of an application for emergency necessary medical utilization management services or a portion thereof.

(5) In the case of follow-up treatment, the clerk shall have ten (10) days to complete an interview on a request for additional treatment to update the financial and other information contained in a previous application for an original diagnosis in accordance with a treatment plan previously approved by the county commissioners.

(6) Upon completion of the interview and investigation of the application or request, a statement of the clerk's findings shall be filed with the county commissioners. <u>Such findings of indigency shall start on the date necessary medical services are first provided.</u>

SECTION 6. That Section 31-3508A, Idaho Code, be, and the same is hereby amended to read as follows:

31-3508A. PAYMENT FOR NECESSARY MEDICAL SERVICES BY AN OBLIGATED COUNTY. (1) Upon receipt of a final determination by the county commissioners approving an application for financial assistance under the provisions

of this chapter, an applicant, or the third party applicant on behalf of the applicant, shall, within sixty (60) days, submit any remaining medical claims pursuant to the procedures provided in chapter 15, title 31, Idaho Code.

(2) Payment shall be made to hospitals or providers on behalf of an applicant and shall be made on the next payment cycle. In no event shall payment be delayed longer than sixty (60) days from receipt of the county claim.

(3) Payment to a hospital or provider pursuant to this chapter shall be payment of the debt in full and the provider or hospital shall not seek additional funds from the applicant.

(4) Within fourteen (14) days after the county payment, the clerk of the obligated county shall forward to the board any application for financial assistance exceeding, at the reimbursement rate, the total sum of eleven thousand dollars ($11,000) in the aggregate per resident in any consecutive twelve (12) month period. A copy of the clerk's findings, the final decision of the county commissioners and a statement of which costs the clerk has paid shall be forwarded with the application to the board.